PLAYGROUP REGISTRATION FORM
Enfield Family Resource Centers

Enfield Street School
1318 Enfield Street
Enfield, CT. 06082
PHONE (860) 253-5144

Harriet Beecher Stowe
117 Post Office Road
Enfield, CT. 06082
PHONE (860) 253-6580

FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

Parent/Guardian Signature_____ Date:_____

Disclaimer Statement:
I/We the parent/guardian of the above named child, understand that I/We are solely responsible for any injuries/accidents that may occur during my child's attendance at the Enfield Family Resource Center events. I/We understand that by signing this form, we do hereby waive, release, absolve, indemnify and agree to hold harmless the Enfield Family Resource Center staff, leaders, aides, and volunteers regarding any activity for any claims arising out of any injury to my child whether the result of negligence or for any other cause.

Parent/Guardian Signature_____ Date:_____

Photo Release Form:
I authorize the Town of Enfield and the Enfield Family Resource Center to record and to use my child's picture in any manner or media (including social media), and to use my child's name, likeness, or other information in connection with the photo. I understand that this picture(s) will not be used for commercial purposes. I agree to hold harmless the Town of Enfield in connection with all claims regarding my picture including legal fees and other costs incurred. I waive any claim to compensation for the use of these pictures and waive the right to inspect or approve any use of my name, likeness and actions. I have read this release and agree to be legally bound by it.

Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
_____

6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
_____

7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
_____
_____

8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
_____ No _____ Yes Explain: _____
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
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For office use only:
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Time: _____
Site: _____
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***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
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Email Address: _____

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Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
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7. Does your child take any medication on a regular basis? _____No _____Yes
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For office use only:
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Time: _____
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***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

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Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
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6. Does your child have any allergies?
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
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Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
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Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

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PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

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Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
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Time: _____
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***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

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What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

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Please answer all questions:

1. Does your child have medical insurance?
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Insurance Provider: _____

2. Was your child born premature?
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How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
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***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

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Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

Parent/Guardian Signature_____ Date:_____

Disclaimer Statement:
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Parent/Guardian Signature_____ Date:_____

Photo Release Form:
I authorize the Town of Enfield and the Enfield Family Resource Center to record and to use my child's picture in any manner or media (including social media), and to use my child's name, likeness, or other information in connection with the photo. I understand that this picture(s) will not be used for commercial purposes. I agree to hold harmless the Town of Enfield in connection with all claims regarding my picture including legal fees and other costs incurred. I waive any claim to compensation for the use of these pictures and waive the right to inspect or approve any use of my name, likeness and actions. I have read this release and agree to be legally bound by it.

Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
_____

6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
_____

7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
_____
_____

8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
_____ No _____ Yes Explain: _____
_____
_____
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
_____
_____
_____
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PLAYGROUP REGISTRATION FORM
Enfield Family Resource Centers

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PHONE (860) 253-5144

Harriet Beecher Stowe
117 Post Office Road
Enfield, CT. 06082
PHONE (860) 253-6580

FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

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Parent/Guardian Signature_____ Date:_____

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Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
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6. Does your child have any allergies?
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7. Does your child take any medication on a regular basis? _____No _____Yes
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For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

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Parent/Guardian Signature_____ Date:_____

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PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
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FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

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Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
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FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
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7. Does your child take any medication on a regular basis? _____No _____Yes
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For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
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Parent/Guardian Signature_____ Date:_____

Photo Release Form:
I authorize the Town of Enfield and the Enfield Family Resource Center to record and to use my child's picture in any manner or media (including social media), and to use my child's name, likeness, or other information in connection with the photo. I understand that this picture(s) will not be used for commercial purposes. I agree to hold harmless the Town of Enfield in connection with all claims regarding my picture including legal fees and other costs incurred. I waive any claim to compensation for the use of these pictures and waive the right to inspect or approve any use of my name, likeness and actions. I have read this release and agree to be legally bound by it.

Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
_____

6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
_____

7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
_____
_____

8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
_____ No _____ Yes Explain: _____
_____
_____
_____

9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
_____
_____
_____
_____

PLAYGROUP REGISTRATION FORM
Enfield Family Resource Centers

Enfield Street School
1318 Enfield Street
Enfield, CT. 06082
PHONE (860) 253-5144

Harriet Beecher Stowe
117 Post Office Road
Enfield, CT. 06082
PHONE (860) 253-6580

FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

Parent/Guardian Signature_____ Date:_____

Disclaimer Statement:
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Parent/Guardian Signature_____ Date:_____

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Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

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Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
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FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
_____

6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
_____

7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
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PHONE (860) 253-6580

FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
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Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
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6. Does your child have any allergies?
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7. Does your child take any medication on a regular basis? _____No _____Yes
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For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
_____

6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
_____

7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
_____
_____

8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
_____ No _____ Yes Explain: _____
_____
_____
_____

9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
_____
_____
_____
_____

PLAYGROUP REGISTRATION FORM
Enfield Family Resource Centers

Enfield Street School
1318 Enfield Street
Enfield, CT. 06082
PHONE (860) 253-5144

Harriet Beecher Stowe
117 Post Office Road
Enfield, CT. 06082
PHONE (860) 253-6580

FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

Parent/Guardian Signature_____ Date:_____

Disclaimer Statement:
I/We the parent/guardian of the above named child, understand that I/We are solely responsible for any injuries/accidents that may occur during my child's attendance at the Enfield Family Resource Center events. I/We understand that by signing this form, we do hereby waive, release, absolve, indemnify and agree to hold harmless the Enfield Family Resource Center staff, leaders, aides, and volunteers regarding any activity for any claims arising out of any injury to my child whether the result of negligence or for any other cause.

Parent/Guardian Signature_____ Date:_____

Photo Release Form:
I authorize the Town of Enfield and the Enfield Family Resource Center to record and to use my child's picture in any manner or media (including social media), and to use my child's name, likeness, or other information in connection with the photo. I understand that this picture(s) will not be used for commercial purposes. I agree to hold harmless the Town of Enfield in connection with all claims regarding my picture including legal fees and other costs incurred. I waive any claim to compensation for the use of these pictures and waive the right to inspect or approve any use of my name, likeness and actions. I have read this release and agree to be legally bound by it.

Parent/Guardian Signature_____ Date:_____

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Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

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Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
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For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
I/We the parent/guardian of the above named child give permission for my child to participate in indoor and outdoor physical activities by the Enfield Family Resource Center. I also give my permission to the program aides to provide snacks and drinks during this time.

Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
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6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
_____

7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
_____ No _____ Yes Explain: _____
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
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PHONE (860) 253-6580

FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
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Parent/Guardian Signature_____ Date:_____

Photo Release Form:
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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
_____

6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
_____

7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
_____ No _____ Yes Explain: _____
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9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
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FAX (860) 741-4029

For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
Email Address: _____

Parent/Guardian General Permission:
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Parent/Guardian Signature_____ Date:_____

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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
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Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
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6. Does your child have any allergies?
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_____
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7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
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8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
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For office use only:
Slot #: _____
Day: _____
Time: _____
Site: _____
ASQ date: _____

***One Form per Child:**

Child's Name: _____ Child's DOB:_____ Gender: ___Male ___Female

Parent's/Guardian's Name(s): _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

___ *Please check here if child is attending with a relative or child care provider, and fill out the section below.*

Child Care Provider or Attending Relative Information:

Name:_____ Relationship to Child:_____
Address: _____
Telephone: _____
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Parent/Guardian Signature_____ Date:_____

PLAYGROUP REGISTRATION FORM page 2

Rev. 09/2014

Enfield Family Resource Centers

Family Doctor: _____ Doctor Phone: _____

Verified Date of Birth: _____ Birth Weight: _____ Place of Birth: _____

What is the primary language spoken **by you** or other persons in your home? _____

What is the primary language spoken **by your child** when he/she is at home? _____

Preschool and/or Kindergarten Experience: ____ Yes _____ No Name of School: _____

Address of School: _____

EMERGENCY CONTACT INFORMATION (Must be local):

Name: _____ Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

PLEASE LIST ALL HOUSEHOLD MEMBERS BELOW:

Name	**Relationship To Participating Child**	**Place of Employment if Applicable**

Ethnicity/Race(Optional):

Participating Child: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Mother/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Father/Guardian: **Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic or Latino
Race: (Please Circle All That Apply) American Indian/Alaska Native Asian White Black or African American Native Hawaiian or Pacific Islander

Please answer all questions:

1. Does your child have medical insurance?
_____No _____Yes
Insurance Provider: _____

2. Was your child born premature?
_____ No _____Yes
How many weeks premature? _____

3. Does your child currently, or have they ever received Birth -3 or Preschool Special Education Services?
_____ No _____ B-3 _____Preschool Sp. Ed.

4. Are you enrolled in the WIC program?
_____ No _____Yes

5. Has your child had any illness, injury, or health issues?
_____ No _____Yes Explain: _____
_____
_____
_____

6. Does your child have any allergies?
_____No _____Yes Explain: _____
_____
_____

7. Does your child take any medication on a regular basis? _____No _____Yes
Explain:_____
_____
_____

8. Do you have any concerns that your child is too quiet or doesn't make sounds like other children their age?
_____ No _____ Yes Explain: _____
_____
_____
_____

9. Please share any additional concerns that you have about your child (developmental, behavioral or medical):
_____
_____
_____
_____